STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 120614-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 17th day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On April 15, 2011, XXXXX, authorized representative of his adult son XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on April 22, 2011.

The Petitioner is enrolled for health care coverage through XXXXX., which is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on May 3, 2011.

The issue in this external review can be decided by a contractual analysis. The contract here is BCBSM's *Community Blue Group Benefits Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On December 23, 2010, the Petitioner cut his chin. He was taken to XXXXX Hospital near his home in XXXXX where he was treated by the doctor on call, XXXXX, M.D. XXXXX Hospital participates with the XXXXX Blue Cross Blue Shield plan but Dr. XXXXX does not. Dr. XXXXX charged $3,544.00 for the treatment he provided:

Wound repair	$2,752.00
Emergency basis	$377.00
Consultation	$415.00
TOTAL	$3,544.00

BCBSM paid its approved amount of $425.66 for the wound repair. The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on March 22, 2011, and issued a final adverse determination dated March 25, 2011.

III. ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's December 23, 2010, care provided by XXXXX?

IV. ANALYSIS

Petitioner's father argues that all of XXXXX's charges should be paid because his services were provided on an emergency basis and there was no opportunity to obtain the services of a participating provider.

BCBSM states that it paid the full approved amount for the emergency treatment the Petitioner received.

In its final adverse determination, BCBSM wrote:

> XXXXX billed for wound repair ($2,752.00), services provided on an emergency basis ($377.00) and a consultation ($415.00). We paid 100 percent of the approved amount for wound repair. Consideration for the emergency charge and the consultation is included in the allowance for the laceration repair, and cannot be reimbursed separately.
>
> * * *
>
> We realize that you sought out treatment at a Blue Cross Blue Shield participating hospital. However, although a hospital participates with the local Blues plan, the same is not necessarily true for the professional providers that perform services within the hospital.

Commissioner's Review

Under the Petitioner's health care plan, enrollees incur the least out-of-pocket cost if they receive services from providers who participate with BCBSM. Section 4 of the certificate explains the consequences when enrollees use nonparticipating providers:

> If the nonpanel provider is nonparticipating, you will need to pay most of the

> charges yourself. Your bill could be substantial. . . .
>
> * * *
>
> **NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

The certificate describes how benefits are paid when services are received from a nonparticipating provider like XXXXX. BCBSM pays only its approved amount for covered services. The term 'approved amount' is defined in section 7 of the certificate:

> The lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

There is nothing in the certificate that requires BCBSM to pay more than its approved amount, even in an emergency or even if there are no participating providers available. The Commissioner finds BCBSM correctly processed the claims for XXXXX treatment under the terms and conditions of the certificate.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of March 25, 2011, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's treatment of December 23, 2010.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, P.O. Box 30220, Lansing, MI 48909-7720.